APPLICATION FOR CARE AT CELEBRATION FAMILY CHIROPRACTIC
Scoliosis Reduction Center

604 Front Street Celebration, FL 34747 Phone: 321-939-2328

Today's Date: _____ Who referred you to our clinic? _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ____-____-____ Age:_____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Home Phone: _____ Mobile Phone:_____

☐ I authorize my email and phone to be added to Celebration Family Chiropractic database for email, text alerts and product promotion

Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐ Yes ☐ No

Driver's License #: _____ Occupation:_____

Employer:_____ Work Phone: _____

Spouse's Name:_____ Spouse's Employer: _____

Number of children and ages: _____

Name & Number of Emergency Contact:_____ Relationship:_____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____

Secondarily: _____ Third: _____ Fourth: _____

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day

How long does it last? ☐ constant ☐ on and off during the day ☐ It comes and goes throughout the week

Is your problem the result of ANY type of accident? ☐ Yes ☐ No

If yes, identify type: ☐Auto ☐Work ☐ Home ☐Other (*please explain*):_____

Date of Accident: ____/____/____ Approximately what time that day?_____am _____pm

Have you reported this accident to anyone? ☐ No ☐ Yes **If yes,** to whom:_____

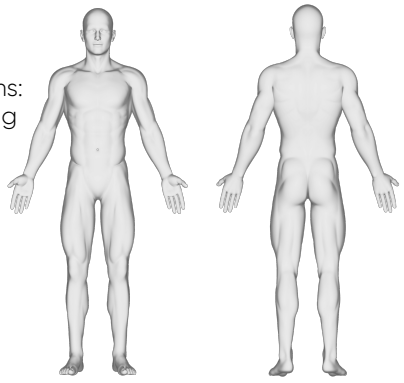
Condition(s) ever been treated by anyone in the past? ☐ Yes ☐ No

If yes, when: _____ by whom?_____ How long were you under care?_____

What were the results? _____

Name of Previous Chiropractor:_____ ☐ N/A

***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R=Radiating **B**=Burning **D**=Dull **A**=Aching **N**=Numbness **S**=Sharp/ Stabbing **T**=Tingling



What relieves your symptoms? _____

What makes them feel worse? _____

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

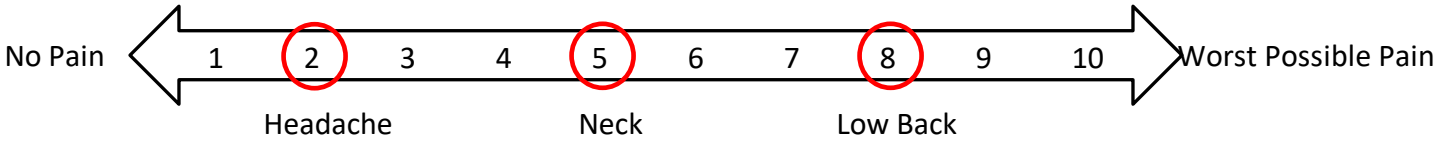
Name:_____ Date:_____

INTENSITY RATING

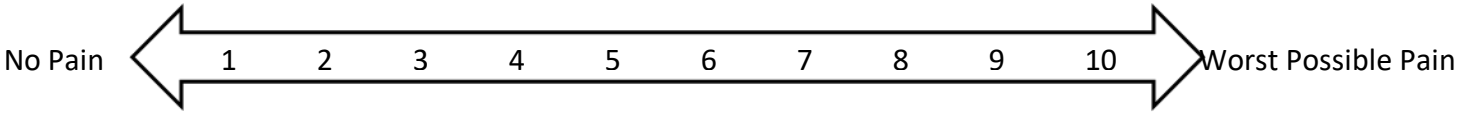
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

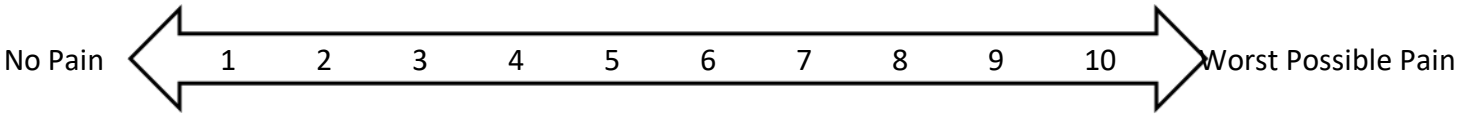
Example



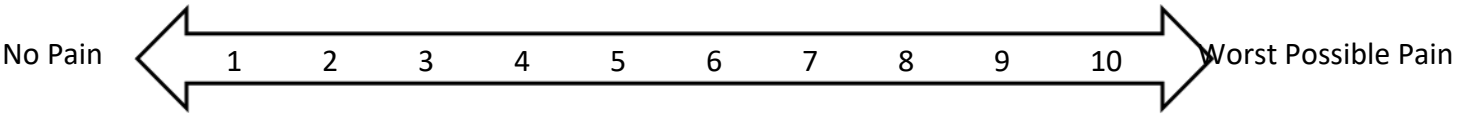
1. What is your pain **RIGHT NOW**?



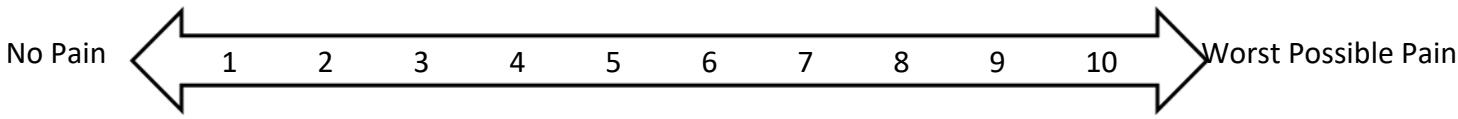
2. What is your **TYPICAL** or **AVERAGE** pain?



3. What is your pain level **AT ITS BEST** (How close to "0" does your pain get at its best)?



4. What is your pain level **AT ITS WORST** (How close to "10" does your pain get at its worst)?



LIST PRESCRIPTION & NON-PRESCRIPTION DRUGS YOU TAKE:

_____

_____

_____

Name:_____ Date:_____

ACTIVITIES OF DAILY LIVING

Identify how your current condition is affecting your ability to carry out daily activities that are routinely part of your life:

Carrying Groceries	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Pet Care	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Driving	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Household Chores	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Lifting Children	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Reading/Concentration	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Bathing	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Dressing	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Washing/Bathing/Shaving	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Sleep	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Sitting	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Standing	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Yard Work	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Walking	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Dishes	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Laundry	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Taking out Garbage	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Other	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Other	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	

Please give us more information regarding your most restricted activity due to your condition and your usual ability before you suffered from your condition.

LIST RESTRICTED ACTIVITY:		CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
EXAMPLE:	Walking without pain	¼ Mile	2 Miles
EXAMPLE:	Sitting without pain	15 minutes	4 Hours

_____

_____

_____

_____

Name:_____ Date:_____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes

If yes how many times? _____When was the last episode?_____

How did the injury happen?_____

Other forms of treatment tried? ❑ No ❑ Yes **If yes**, what type of treatment: _____

Who provided it?_____How long ago?_____ What were the results? ❑ Favorable ❑ Unfavorable→

Please explain: _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on your body:

_____

When was your most recent auto accident? _____

What speed was the collision? _____

Type of impact: Front Impact / Side Impact / Rear Impact

Was treatment received? Please describe _____

When was your most recent strain / stress at work? _____

Please describe the manner of the injury _____

Was treatment received? Please describe _____

Does your job require you remain in long term stressful postures?_____

(i.e. all day seating, repeated lifting, long term computer use)

Spinal traumas in the past?_____

(i.e. Collision, quick burst, repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track)

Trauma as a child?_____

(i.e. fall/ impact to your head, concussion, fall onto your back/tailbone, biking accident)

Please mark P for in the Past, C for Current, N for Never

___Headache	___Pregnant (Now)	___ Dizziness	___Prostate Problems	___Ulcers
___Neck Pain	___Frequent Colds/Flu	___Loss of Balance	___Impotence/Sexual Dysfun.	___Heartburn
___Jaw Pain, TMJ	___Convulsions/Epilepsy	___Fainting	___Digestive Problems	___Heart Problem
___Shoulder Pain	___Tremors	___Double Vision	___Colon Trouble	___High Blood Pressure
___Upper Back Pain	___Chest Pain	___Blurred Vision	___Diarrhea/Constipation	___Low Blood Pressure
___Mid Back Pain	___Pain w/Cough/Sneeze	___Ringing in Ears	___Menopausal Problems	___Asthma
___Low Back Pain	___Foot or Knee Problems	___Hearing Loss	___Menstrual Problem	___Difficulty Breathing
___Hip Pain	___Sinus/Drainage Problem	___Depression	___PMS	___Lung Problems
___Back Curvature	___Swollen/Painful Joints	___Irritable	___Bed Wetting	___Kidney Trouble
___Scoliosis	___Skin Problems	___Mood Changes	___Learning Disability	___Gall Bladder Trouble
___Numb/Tingling arms, hands, fingers		___ADD/ADHD	___Eating Disorder	___Liver Trouble
___Numb/Tingling legs, feet, toes		___Allergies	___Trouble Sleeping	___Hepatitis (A,B,C)
___Broken Bone	___Dislocation	___Tumors	___Fracture	___Rheumatoid Arthritis
___Disability	___Cancer	___Heart Attack	___Osteo Arthritis	___Diabetes

Name:_____ Date:_____

PAST HISTORY RELATED TO CURRENT CONDITION

Identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:

	WHAT	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →				
SURGERIES →				
CHILDHOOD DISEASES →				
ADULT DISEASES →				

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

2. Alcoholic Beverage: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

3. Recreational Drug use: occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

4. **Hobbies -Recreational Activities-** Exercise: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes

If yes whom: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister's ❑ brother's ❑ son(s) ❑ daughter(s)

Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know

2. Any other hereditary conditions the doctor should be aware of? ❑ No ❑Yes:_____

I hereby authorize payment to be made directly to Celebration Family Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Celebration Family Chiropractic for any and all services I receive at this office.

_____ ____/____/____

Patient or Authorized Person's Signature Date Completed

_____ ____/____/____

Doctor's Signature Date Form Reviewed

Celebration Family Chiropractic
Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Celebration Family Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

REGARDING: Chiropractic Scoliosis Treatment (Adjustments, Modalities, and Therapeutic Procedures)

I have been advised of the above as well as the standards associated with scoliosis treatment in regards to watching and waiting, bracing and surgery. I have also been informed of the risks associated with not following those standards. I'm also aware that there is no guarantee or promise of any results and I am aware that the scoliosis can still progress. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care and under my free will choose not to follow the standards associated with scoliosis treatment.

_____ ____/____/____ _____*Witness Initials*

Patient or Authorized Person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on ____/____/____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

MALES/FEMALES: By my signature below, I understand and give consent to be x-rayed if the doctor deems necessary.

_____ ____/____/____ _____*Witness Initials*

Patient or Authorized Person's Signature Date

Celebration Family Chiropractic
Notice of Privacy Practice

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. Once you have read this notice, please sign.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -we may call your home and leave messages regarding a missed appointment or notify you of changes in practice hours or up coming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your patient information

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of this Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To request amendments to information. However, like restrictions, we are not required to agree to them.
6. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like a copy on a disc, there will be a fee, which is your responsibility.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Tina at 321-939-2328. If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

I have read and understand Celebration Family Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _ _
Patient's Printed Name DOB

_____ / /
Patient Signature Date

_____ / /
Witness Date

Celebration Family Chiropractic
Office Policies

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read "Our Office Policies", if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your Application for Care, please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved, and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

☐ PATIENT PRIVACY – Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

☐ YOUR CARE - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at Celebration Family Chiropractic is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctors use a myriad of techniques to accomplish this goal, including but not limited to the latest techniques for spinal correction. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving you overall health.

☐ FIRST THINGS FIRST- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. You will be notified in advance, if any further fees will be applicable. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

☐ PATIENT'S REPORT OF FINDINGS – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your Exam, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

I hereby acknowledge that I have read and understood the practices 'Office Policies'. This signature page will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies 'as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

_____ _____
Patient's Printed Name DOB

_____ _____
Patient Signature Date

_____ _____
Witness Date